STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	05/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DRIVE CARMEL, IN46032

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: May 16, 17, 18, 19, 20 and 23, 2011 Facility number: 000095 Provider number: 155181 AIM number: 100290490 Survey team: Rita Mullen, RN, TC Janet Stanton, RN Michelle Hosteter, RN Barbara Hughes, RN Census bed type: SNF/NF: 104 SNF: 42 Total: 146 Census payor type: Medicare: 38 Medicaid: 79 Other: 29 Total: 146 Sample: 24 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 6/1/11 by Jennie Bartelt, RN.			
F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to have a comprehensive assessment for 1 of 4 residents reviewed related to assessment of dialysis access	F0272	Resident #123 dialysis access site was assessed and documented.Residents with a dialysis access site have been identified. All residents with	06/22/2011

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	sites in a sample of 24. [Resident #123] Findings include: Record review was completed for Resident #123 on 5/23/211 at 9:15 A.M. Diagnoses included, but were not limited to, end stage kidney disease, liver disease, ascites, and weakness. Since readmission on 4/21/11, Nurses Notes, Medication Administration Record [MAR] and Treatment Administration Record [TAR] indicated there was no assessment for the resident's dialysis site. In an interview with the DON [Director of Nursing] on 5/23/11 at 9:55 A.M., she indicated that typically the assessments for dialysis shunts are located in the MAR, the TAR or the Nurses Notes. She looked at the current MAR and TAR and indicated that they were not there and they are indicating that they are not completing the assessments like they should. 3.1-31(c)(1)		dialysis access sites have had their access site assessed and documented.The frequency of the assessment is determined per physician order or at a minimum of every 24 hours . The systemic change includes that all current patients will have dialysis access sites assessed per new policy. The systemic change for new admissions includes review at daily Clinical Standup Meeting of orders to include the assessment of the dialysis access site per policy. The licensed nursing staff will be re-educated on the assessment of dialysis access sites, the frequency and the appropriate location for the access site documentation. The unit manager &/or designee will audit 100% of the medical records of those residents with dialysis access sites weekly to ensure that the site has been assessed and documented as indicated. The results of these audits will be presented to the Quality Assurrance Commitee monthly by the Director of Nursing. The QA committee can make recommendations for changes if neccessary. This audit will continue weekly for 3 months and then QA Committee will determine the frequency of audits for the next 9 months..	

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F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow the care plan for assessment of the dialysis access shunt and daily weights for 1 of of 4 residents reviewed with dialysis access sites and daily weights in a sample of 24. [Resident #123] Findings include: Record review for Resident #123 was completed on 5/23/11 at 9:15 A.M. Diagnoses included, but were not limited to, end stage kidney disease, liver disease, ascites, and weakness. A care plan for Resident #123, dated 4/22/11, edited on 4/25/11, indicated, "...Monitor weight daily Notify MD and family of significant weight change...MONITOR SHUNT SIE [SIC] FOR S/S [signs and symptoms] OF INFECTION, CHECK BRUIT [sounds expected for a dialysis shunt]/THRILL [feeling for pulse through a dialysis shunt]...."	F0282	Resident #123 dialysis access site was assessed and documented per careplan. Resident #123 weight has been obtained per physician order and as careplanned. Resident #123 careplan has been updated to reflect the resident's current plan of care. Any other residents with careplans to assess dialysis access sites &/or daily weights have been identified. All residents with careplans to assess their dialysis access sites have had their access site assessed and documented. Those residents with a careplan or physician's order that reflect daily weights have been weighed daily. Careplans have been updated to reflect the residents current plan of care. New admissions with a dialysis access site or daily weight will be assessed per policy and procedure. Care plan initiated and weight obtained as ordered.The systemic change includes that all new physician orders will be reviewed at the daily clinical stand up meeting five days a week, the care plan will be reviewed and updated as needed.The licensed	06/22/2011

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	The assessment of dialysis shunt could not be found in Nursing Notes, MAR [Medication Administration Record, or the TAR [Treatment Administration Record]. The record of vital signs indicated the weights were not being completed daily. Documentation reviewed was from readmission on 4/21/11 to 5/23/11. In an interview with the DON [Director of Nursing] on 5/23/11 at 9:55 A.M., she indicated that typically the assessments for dialysis shunts are located in the MAR, the TAR or the Nurses Notes. She looked at the MAR for May 1st through May 23rd and the TAR for May 1st through the 23rd, and indicated that the assessments were not there and that they are not documenting the assessments like they should. When interviewed as to where the daily weights were documented, she indicated the vitals section and indicated she would print a copy. When she provided the copies of the weights, she indicated the weights had not been done daily. 3.1-35(g)(2)		nursing staff will be re-educated on following the resident's plan of care for the assessment of dialysis access sites and daily weights. Careplans will be updated to reflect the resident's current plan of care accordingly.The unit manager &/or designee will audit the medical record of those residents with careplans for assessment of dialysis access sites and daily weights weekly to ensure that site has been assessed and documented as indicated and the weight has been obtained as careplanned. This audit will continue for a duration of three months on a weekly basis and monthly audits will be preformed for the next nine months. The results of these audits will be presented monthly to the Quality Assurance Committee by the Director of Nursing. If neccessary, the QA Committee can make recommendations for changes.	

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to provide care and services related to bowel function and elimination management for 2 of 2 residents who were documented as having no B.M. (bowel movement) for more than 3 days, with a "regular" pattern defined in the facility Bowel Management Policy/Procedure as every 3 days; in a sample of 24 residents reviewed. [Residents #29 and #125] Findings include: 1. On 5/20/11 at 11:20 A.M., the Administrator provided an undated paper titled "Management of Constipation." The paper included, but was not limited to, the following information: "It is the policy of this facility to assist residents to maintain regular bowel movements, at least every 3 days or per the resident's normal pattern.	F0309	Resident #29 and Resident #125 bowel movements have been monitored daily. Resident #29 & Resident #125 have not had a negative outcome related to their bowel function. Both residents bowel function have been maintained within the facility's Bowel Management Policy/Procedure. Orders for routine or P.R.N bowel medications have been obtained as needed. All residents have the potential to be affected. All residents bowel movements have been monitored daily with interventions as indicated in the facility's Bowel Management Policy/Procedure if needed. The nursing staff has been re-educated on the facility's Bowel Management Policy/Procedure. Daily reports of the resident's bowel movements are printed and monitored by the licensed nursing staff. Interventions are administered per physician orders. Newly admitted residents' physician orders will be reviewed for either routine or P.R.N. bowel medications as indicated by the	06/22/2011

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	The bowel elimination pattern of each resident is considered regular if the resident has at least one movement every three days. Constipation is defined as having 2 or fewer bowel movements per week.... Laxatives should be considered when there is no bowel movement for 3 or more days.... PROCEDURE: * It shall be the responsibility of the charge nurse for each unit to monitor the documentation of bowel movements every shift. * The Nursing Assistants will indicated which residents have had a bowel movement via documentation in the computerized Point of Care system. *The night shift nurse will print a BM Monitoring Report from the Point of Care System nightly and provide for the following shifts with the 24 hour report sheets. * The Evening Shift Nurse will offer the PRN [as needed] laxative to any resident who has not had a B.M. in 3 days. If the laxative is refused, this will be recorded on the BM report and in the nurse's notes		resident's history and/or current medication regimen. If needed, physician orders for these medications will obtained. The unit manager &/or designee will review the residents bowel record daily to ensure each residents bowel pattern is maintained within the facility's Bowel Managment Policy/Procedure. The Director of Nursing will report monthly to the Quality Assurance Committee a summary of the facility's compliance within the facility's Bowel Managment Policy/Procedure. The QA Committee can recommend changes if necessary.	

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	of the applicable patient. Laxative (MOM 30 cc.) [Milk of Magnesia 30 cubic centimeters] will be offered on the 3rd day. * If the resident has not had a BM within 24 hours after receiving MOM (or refusal of MOM), a (Dulcolax) suppository will be offered/given. Refusal of the (Dulcolax) suppository will be recorded on the BM report and the nurses notes of the applicable patient. * If the resident has not had a BM within 24 hours after receiving the suppository, and (Fleets) enema may be offered/given. If no results are received within 12 hours of the enema, the physician will be notified." 2. In an interview during the initial orientation tour on 5/16/11 at 12:03 P.M., L.P.N. #10 indicated Resident #29 had a past history of a C.V.A. (stroke). The nurse indicated the resident was alert but forgetful, hard of hearing, and was able to transfer with the physical assistance of 2 staff. The clinical record for Resident #29 was reviewed on 5/19/11 at 2:00 P.M. Diagnoses included, but were not limited to, right C.V.A. with left hemiplegia and hemiparesis [paralysis] and left facial			

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	droop, atrial fibrillation, hypertension, and chronic urinary incontinence. On 2/15/11, the resident sustained a posterior fracture and dislocation of the right shoulder during seizure activity. Upon discharge from an acute care hospital on 2/18/11, the resident had orders for a scheduled narcotic pain medication, to be given twice daily, with the same medication to be given every 6 hours PRN. The May 2011 physician order recap [recapitulation] sheet listed orders which included, but were not limited to, the following medications: Norco/Hydrocodone [a narcotic pain medication] one tablet routinely every 4 hours, Metoprolol [a beta-blocker hypertension medication] twice a day; Oxybutynin [a urinary anti-spasmotic medication]; Pantoprazole [a treatment for gastro-intestinal reflux disease]; and Simvastin [a cholesterol-reducing medication]. All of these medications have an adverse reaction potential for causing constipation. There were no routine or P.R.N. bowel medications listed on the recap sheet. A Significant Change M.D.S. [Minimum Data Set] assessment, dated 2/23/11, indicated the resident had moderate difficult with hearing, had clear speech			

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	which could be understood, understood others, had correct and accurate recall memory, was dependent on physical assistance of 1 staff person for all daily care--including toileting, and was continent of bowels. One Care Plan entry, with a "Problem Start Date" of 4/8/11 addressed a problem of "Resident has constipation, due to decreased activity and scheduled pain medication;" with a "Goal" of "Resident will not exhibit signs of fecal impaction." Interventions/Approaches were listed as: "Serve diet and encourage, assist with feeding; Administer medications per M.D. order: Monitor effectiveness and side effects; Monitor of signs of constipation (decreased bowel sounds/abdominal pain/distention/decreased appetite/fever, etc.); Administer: PRN laxatives per M.D. order." A print-out from the computerized Point of Care system for B.M.s for this resident indicated the following: 5/1/11 at 9:42 P.M.--Large Entries on 5/2/11 at 8:10 P.M., 5/3/11 at 2:45 P.M., 5/3/11 at 10:54 P.M., 5/4/11 at 11:08 A.M., 5/4/11 at 10:53 P.M., 5/5/11 at 3:03 P.M., and 5/5/11 at 10:20 P.M. all indicated "None" for B.M.s.			

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5/6/11 at 1:17 P.M.--Large

Entries on 5/8/11 at 8:46 P.M., 5/9/11 at 2:55 P.M., 5/9/11 at 10:20 P.M., 5/10/11 at 2:33 P.M., 5/10/11 at 2:43 P.M., 5/10/11 at 10:49 P.M. all indicated "None" for B.M.s.

5/11/11 at 2:02 P.M.--Large. A "Nurse's Note" progress note, dated 5/11/11 at 4:00 P.M., indicated "MOM [given according to the Policy/Procedure protocol] given for complaint of constipation this A.M. Results this afternoon after lunch--X-Large [extra large] B.M."

5/11/11 at 10:10 P.M.--Medium

The subsequent chronological entries on 5/13/11 at 10:39 P.M., 5/14/11 at 3:01 P.M., 5/15/11 at 1:14 A.M., and 5/15/11 at 10:53 A.M. all indicated "None" for B.M.s.

5/15/11 at 2:17 P.M.--Large

With the exception of the the Nurse's Note on 5/11/11 at 4:00 P.M., there were no other progress notes addressing the resident's B.M. status or use of other treatments for the time frames when her elimination was marked as "None."

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	In an interview during the daily conference on 5/19/11 at 3:45 P.M., the Director of Nursing indicated she had identified a problem with nursing staff not consistently entering information about B.M.s in the computerized Care Tracker system or following up according to the facility's Bowel Management protocol. She indicated she was still in the process of reviewing the system and inservicing staff. 3. Record review for Resident #125 was completed on 5/17/11 at 9:10 A.M. Diagnoses included, but were not limited to, multiple sclerosis, anxiety, depression, malnutrition, and fecal impaction. The bowel records for Resident #125 indicated that the resident did not have a bowel movement 5/14, 5/15, 5/16, 5/17, or 5/18/11. The resident's bowel management medications were as follows: Bisacodyl 10 mg per rectum every 8 hours PRN [as needed] for constipation, Bisacodyl 10 mg tab by mouth every 12 hours PRN for consitpation, senna/docusate every 12 hours PRN for constipation, oil rentention enema 133 ml per rectum every 12 hours PRN, and Miralax 17 gm in 8 ounces of water every 12 hours PRN for constipation.			

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	Resident #125 had three medications which have the side effect of constipation. She received Duloxetine 30 mg daily, Ferrous Sulfate 325 mg daily, and Baclofen 20 mg, a muscle relaxant, five times a day. The MAR [Medication Administration Record] indicated that the resident had received Bisacodyl 10 mg rectal suppository on 5/13/11 and Senna/Docusate 1 tab on 5/17/11. No results had been documented on the MAR regarding the resident having a bowel movement. The nurses notes for 5/12/11 through 5/18/11 did not indicate any assessment of bowels done or that the resident had a bowel movement. In an interview with the DON 5/24/11 at 3:15 P.M., when asked how long they wait before a resident has a bowel movement, she indicated that the policy for bowel movements is three days. 3.1-37(a)			

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F0314 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to maintain the inflation of a special pressure-relieving air mattress at the correct level in order to maximize the effectiveness of the equipment in treatment of a pressure sore for 1 of 6 residents reviewed who utilized special air mattress equipment in a sample of 24 residents reviewed. [Resident #125] Findings include: In an interview during the initial orientation tour on 5/16/11 at 11:05 A.M., LPN # 13 indicated Resident #125 was admitted with a large pressure sore that required a specialty low air loss pressure-relieving mattress. Record review for Resident #125 was completed on 5/17/11 at 9:10 A.M. Diagnoses included, but were not limited to, multiple sclerosis, anxiety, depression, malnutrition, and fecal impaction.	F0314	Resident #125 specialty low air loss pressure-relieving device has been set to the recommended setting per the manufacturer's guide according to weight and resident comfort. Although, during observation during survey, resident #125 bed was set at an higher setting, the resident's wound has shown improvement. The current setting has been communicated to the staff.Residents with a low-air loss pressure-relieving mattress have the potential to be affected and have been identified. Those resident's specialty bed settings have been reviewed and set per the manufacturer's guide for each resident's weight and comfort. The settings have been communicated to the staff. The systemic change includes that upon placement of a low air loss mattress, the person placing the mattress on the bed will obtain the patients weight and inflate/set pump accordingly. Resident's can then request a change in setting per comfort level accordingly.The nursing staff have been educated on the	06/22/2011

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	The Progress Notes, dated 5/5/11, indicated Resident #125 had a sacral decub (pressure wound), Stage IV, which measured 5.1 x 3.0 x 0.5. Vital signs records for 5/23/11 indicated the resident weighed 123 pounds. The DON [Director of Nursing] provided on 5/18/11 at 9:00 A.M. a document titled "Resident Care Record," used by the nursing assistants to assist residents with their daily care. For Resident #125 there was nothing on the document to indicate the correct setting for Resident #125's bed. The care plan, dated 5/16/11, did not indicate the resident had a specialized low air loss mattress or what the setting for it should be. During observation on 5/18/11 at 10:35 A.M., Resident #125 was in her bed. The bed was set at "6" and a "floats" setting. During observation on 5/24/11 at 2:15 P.M., Resident #125 was in her bed. The bed was set at "5" and a "floats" setting. In an interview in regard to the settings for Resident #125's specialty bed on 5/23/11 at 3:15 P.M., the DON indicated the bed was set according to weight. When asked what the setting was on Resident #125's bed, she indicated "5,"		specialty low-air loss pressure-relieving manufacturer setting guide in regards to the resident's weight and comfort. The nursing staff will ensure that the mattress settings are maintained each shift. The unit manager &/or designee will round three times per week to ensure that bed settings remain at the manufacturer's guideline and resident comfort. This audit will continue monthly for the next 9 months. The Director of Nursing will report the results of these rounds to the Quality Assurance Committee monthly. The QA committee can make recommendations if necessary.	

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	which is for 140 pounds. A manufacturer's guide for Resident #125's bed was provided by the Administrator on 5/20/11 at 11:20 A.M. The MaXair bed SCM LAL 2000 model indicated on the "...Patient weight recommendations...100-140 pounds is setting 4; 140-175 pounds is setting 5; 175-200 pounds is setting 6...." 3.1-40(a)(2)			
F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure alarms used to alert staff to residents' unassisted transfers were turned on and functioning, for 2 of 7 residents reviewed for falls in a sample of 24 residents reviewed. [Residents #16 and #99] Findings include: 1. In an interview during the initial orientation tour on 5/16/11 at 11:17 A.M., L.P.N. #10 indicated Resident #16 was	F0323	Resident #16 & Resident #99 alarm box &/or sensor pad was immediately removed and replaced with functioning equipment. All residents that utilize alarms as an alert to the staff that the resident may be transferring without assistance have been identified. All alarms have been checked for functionality and acceptable working condition, i.e observing for any frayed wiring etc.The nursing staff have been re-educated to verify that any alarms are functional and in acceptable working conditions.	06/22/2011

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	confused, and had floor, wheelchair, and bed pressure-activated alarms. On 5/19/11 at 1:40 P.M., C.N.A. #6 as observed to transport the resident in her wheelchair from the hallway outside of the Nurse's station to her room, to lay her down in bed. A blue light on the front of the wheelchair alarm unit was observed to be blinking on and off. Once in the resident's room, C.N.A. #6 assisted the resident to stand up from the wheelchair, pivot, and sit and lie down on the bed. The wheelchair alarm unit did not sound after the resident stood up, nor did it sound at any time after the resident was placed in bed. C.N.A. #6 did not comment on the alarm not sounding when she transferred the resident. In an interview on 5/19/11 at 1:50 P.M., C.N.A. #6 indicated the facility used a lot of different types of alarms, and she did not know why the wheelchair alarm did not alarm when the resident stood up. In an interview on 5/19/11 at 2:00 P.M., L.P.N. #7 also indicated the facility used a number of different alarms. She indicated staff hadn't received an inservice or other instructions/directions for the use of each		The nursing staff will verify the alarm status at anytime while providing care to the residents that have alarms. The unit manager/designee will conduct walking rounds three times a week to verify that the alarms are functional and in good working conditions. The results of these rounds will be presented to the Quality Assurance Commitee monthly by the Director of Nursing. The QA Committee can make any recommendations as needed.	

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	type. She indicated when she checked this particular type of alarm for function, she "just looked for the blinking blue light" on the front of the unit, which she thought meant the alarm was functioning correctly. She was not sure why the alarm did not sound even though the light was blinking. During an interview at that same time, L.P.N. #8 indicated C.N.A. #6 had come to her about the alarm not sounding. She had just now checked the alarm and pad, and had found frayed wiring from the alarm unit to the pressure pad. She replaced the pad. She indicated at first that she was not sure how the alarm was supposed to work, but after examining it, determined that the alarm unit remained on at all times. When pressure was applied to the pad, the alarm was then activated. Once the pressure on the pad was removed, the alarm was then supposed to sound until the button on the front was pressed, to deactivate the alarm. The clinical record for Resident #16 was reviewed on 5/20/11 at 1:35 P.M. Diagnoses included, but were not limited to, dementia, encephalopathy, insulin-dependent diabetes, macular degeneration with blindness, osteoarthritis, muscle weakness, and history of falls.			

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A "Fall Risk Assessment" form, dated 5/18/11, indicated the resident had a "fall risk" score of "25." A key on the form indicated a score of "10 or above" indicated "high risk of falls."

A Care Plan entry, with a "Problem Start Date" of 5/18/11, addressed a problem of "[resident's name] at risk for falling due to poor safety awareness." Interventions/approaches included, but were not limited to, the following: "Chair and bed sound alarms; floor mat; give resident verbal reminders not to ambulate/transfer without assistance...."

2. On 5/16/11 during initial tour, LPN #10 indicated that Resident #99 had bowel and bladder incontinence, communication problems, was cognitively impaired, and had bed and chair alarms.

Record review for Resident #99 was completed on 5/20/11 at 9:20 A.M. Diagnoses included, but were not limited to, dementia, Alzheimer's disease, abnormality of gait, and history of falls.

The MDS [Minimum Data Set] assessment, dated 12/14/10, indicated that the resident had two falls during the last three months. A care plan dated 12/21/10 for falls indicated "...Equip resident with device that monitors rising. Bed alarm in

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	bed and chair alarm when up in wheel chair..." The DON [Director of Nursing] provided on 5/18/11 at 9 A.M. a document titled "Resident Care Record" which is what the aides use to assist residents with their daily care. This sheet indicated that Resident #99 was to have bed and chair alarms. During observation on 5/20/11 at 11:30 A.M., Resident #99 was sitting in her wheelchair in her room alone. The resident had her head down and eyes closed. The chair alarm was attached to the back of the wheelchair, and no light was flashing. The on/off switchn was noted to be in the off position. The Unit Manager, LPN #9, was requested to look at the alarm at this time. CNA #12 was in the room at this time and was preparing to take the resident out of the room. LPN #11 looked at the alarm and saw no light was flashing. She then turned it over and noted that it was in the off position and said, "Oh" and turned to the on position, at which time there was a beeping sound heard. She talked to CNA #12 at this time and discussed the need for the alarm to be on. 3.1-45(a)(2)			

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F0371 SS=E	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure that 1 of 2 convection ovens was cleaned in a timely manner and was free from burnt-on food spillage in 1 of 1 main kitchens where food was prepared/cooked. The deficient practice had the potential to impact 138 of 146 residents. Findings include: In an interview during the initial kitchen inspection on 5/16/11 at 10:10 A.M., the Dietary Manager indicated she had been in the position only three weeks. She indicated she had not been able to locate any type of cleaning schedule for the dietary department from the previous Dietary Manager. She was currently working on formulating some type of cleaning schedule, but at the moment all instructions for cleaning the various equipment and storage areas was given by her verbally to the dietary employees. During the full kitchen inspection tour on	F0371	None of the 138 residents that potentially could have been impacted by this alleged deficient practice were affected. The convection oven has been cleaned.Any resident that received an oral diet has been identified. The convection oven has been cleaned and is maintained on a routine cleaning schedule.The dietary employees have been re-educated on convection oven cleaning procedure and schedule. The systemic change is the cleaning of the convection oven has been placed on a routine cleaning schedule.The dietary manager/designee will monitor the cleaning of the convection oven weekly to ensure that the routine cleaning schedule is followed for the next 12 months.. The Administrator will report monthly to the Quality Assurance the results of the dietary manager/designee's weekly reviews. The QA Commitee can make recommendations as necessary.	06/22/2011

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	Wednesday, 5/18/11 at 9:15 A.M., with the Dietary Manager in attendance, the following was observed: Two convection ovens, one stacked on top of the other, were observed in the main kitchen area across from the prep table. The bottom convection oven had heavy, black, burnt-on food spillage on the inside floor of the oven, with some black splatters from burnt food spillage on each side wall. In an interview at that time, the Dietary Manager indicated she had just gotten her supply order for oven cleaner on Monday, 5/16/11. She indicated there had been no oven cleaning supplies when she started three weeks ago in her position as Dietary Manager. 3.1-21(i)(3)			

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F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on record review and interview, the facility failed to record the disposition of controlled medications of a resident that was discharged from the facility. The deficient practice affected 1 of 3 residents whose closed records were reviewed related to disposition of medications in a sample of 24. (Resident #146)	F0431	Resident #146 has discharged from the facility.Any resident that discharges from the facility has the potential to be affected by the alleged deficient practice. A closed record audit is conducted to verify that all medications have been accurately reconciled post discharge.The licensed nursing staff have been re-educated on	06/22/2011

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	Findings include: The closed clinical record of Resident #146 was reviewed on 5/20/11 at 10:00 A.M. The Medication Administration Record, dated for the month of April 2011, indicated Resident #146 had orders for APAP/codeine 300-30 mg (milligram)(a pain medication) every 4 hours as needed and Diazepam 5 mg (anxiolytic medication) by mouth at bedtime. The disposition of medications indicated all the medications, with the exception of the APAP/codeine and the Diazepam, were returned to the pharmacy on 4/17/11. There was no record of the disposition of these two drugs. During an interview with the Director of Nursing, on 5/23/11 at 2:00 P.M., she indicated a record for the disposition of the APAP/codeine and the Diazepam could not be found. 3.1-25(s)		the process of drug disposition when a resident discharges from the facility. The unit manager/designee will audit the reconcilation of the resident's medication once the resident discharges. The systemic change is the medical records department will conduct an additional audit of the closed record to additionally audit for accurate drug disposition.The Director of Nursing will report monthly to the Quality Assurance Committee the results of both the unit manager audit and medical records department audits that will be performed weekly for the first three months. The Director of Nursing or designee will audit monthly for the next 9 months. The QA committee can make recommendations for changes if neccessary.	

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F0441 SS=F	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	A. Based on record review and interview, the facility failed to appropriately screen employees for tuberculosis. This impacted 3 of 12 employees reviewed for tuberculosis screening in a sample of 12.	F0441	Housekeeper #1 has received an annual TB test. Maintenance Employee #2 has received a 2nd step TB test. LPN #4 has received a 2nd step TB test. LPN #4 will have a physical by	06/22/2011

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	This had the potential to impact the 146 residents at the facility. (Housekeeper #1, Maintenance Employee #2 and LPN #4). B. Based on record review and interview, the facility failed to ensure a pre-employment physical exam and of all employment-related examinations for LPN #4. This impacted 1 of 12 employees' records reviewed for record of a physical exam in a sample of 12. This had the potential to impact the 146 residents at the facility. (LPN #4). Findings include: 1. The employee health file of Housekeeper #1 was reviewed on 5/17/11 at 10:00 A.M. The record indicated an annual TB test was not done in 2010 or 2011. The hire date was 12/22/09. 2. The employee health file of Maintenance Employee #2 was reviewed on 5/17/11 at 10:00 A.M. The record indicated the hire date was 1/21/11. The first step TB test had been completed, but not the second step. 3. The employee health file of LPN #4 was reviewed on 5/17/11 at 10:00 A.M. The record indicated the hire date was 3/30/11. The first step TB test had been completed but not the second step.		6/22/11Although 146 residents have the potential to be affected by the alleged deficient practice, no actual resident has been impacted.The Human Resource Director has been re-educated on the requirements and timelines for 1st step and 2nd step TB testing and the requirement of pre employment physicals. The employees have also been re-educated on the requirements and timelines for 1st and 2nd step TB testing. The Human Resource Director will maintain a list for the employee's TB testing schedule and a list of all pre employment physicals. The employee is responsible for ensuring that his/her TB testing schedule is maintained. Any employee that is not in compliance will be not be allowed to work until his/her TB testing schedule is current and pre employment physical is complete. The annual TB test will be conducted with the employee's current employment evaluation. The Human Resource Director will audit the employee files weekly to ensure that the employee's TB testing schedule is current and pre employment physical is present. The Administrator will report these results monthly to the Quality Assurance Committee. The QA committee can make recommendations if neccessary.	

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	During an interview with the Director of Nursing on 5/19/11 at 3:00 p.m., she indicated the facility had no further information regarding the TB testing. B. The employee health file of LPN #4 was reviewed on 5/17/11 at 10:00 A.M. There was no indication a pre-employment physical had been done. During an interview with the Director of Nursing on 5/19/11 at 3:00 p.m., she indicated that the facility did not have any record of a physical exam for LPN #4. 3.1-18(b)(2)			
F0504 SS=D	The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and interview, the facility failed to discontinue a lab order, and obtained labs without a physician's order, for a BMP (basic metabolic panel) for 1 of 14 residents reviewed related to	F0504	An order to discontinue the biweekly lab test was obtained for Resident # 37. Lab company was notified.Any resident that has ordered laboratory tests has the potential to be affected. An audit of the current facility physician	06/22/2011

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	obtaining labs upon physician's orders in a sample of 24. (Resident #37) Findings include: The clinical record of Resident #37 was reviewed on 5/17/11 at 2:00 P.M. Diagnoses included, but were not limited to, chronic pain, high blood pressure and depression. The Physician's summary, dated for the month of November 2010, indicated a Physician's order, dated 4/28/10, for a BMP every two weeks. The Physician's summary, dated for the month of May 2011, indicated Resident #37 did not have a BMP ordered every two weeks. A review of lab results indicated Resident #37 had results for five BMPs for the months of March, April and May 2011. During an interview with the Director of Nursing, on 5/19/11 at 10:00 A.M.,, she indicated Resident #37 had gone to the hospital in November 2010, and when he came back the BMP every two weeks was not ordered, but the lab continued to do tests.		orders to an accumulative listing of orders from the contracted laboratory service has been conducted to ensure that no other resident is receiving any laboratory results that are not an active physician order.The licensed nursing staff have been re-educated to clarify any new laboratory tests upon a resident's readmission from the hospital with both the physician and the contracted laboratory service and ensuring the discontinuation of those laboratory tests that are not currently ordered by the physician. The unit manager/designee will audit any readmitted resident's medical record for any laboratory testing changes within 72 hours of readmission. A monthly audit will be conducted by the unit manager/designee to compare current physician ordered laboratory testing and those laboratory tests that the contracted laboratory service has ordered. If needed, corrections will be made accordingly. The Director of Nursing will report the results of these audits to the Quality Assurance Committee monthly for 12 months. The QA Committee can make recommendations for changes as necessary.	

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CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DRIVE CARMEL, IN46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	3.1-49(f)(1) STATE FINDINGS 3.1-14 PERSONNEL 1. Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (6) Position in the facility and job description and (7) Documentation of orientation to the facility and to the specific job skills. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to maintain a job description and record of job specific orientation in employees' records . This impacted 2 of 12 employees records reviewed for accurate personnel records in a sample of 12 employees (LPN #3 and LPN #4). Findings include:	F9999	LPN # 3 and LPN #4 both have a signed job description. LPN #4 has been oriented to the care of the cognitively impaired resident and residents' rights. The employee files have been audited and will ensure that all other employee files have both a signed job description and have received job specific orientation by 7/22/11. The Human Resource Director has been re-educated on the components of a complete employee file. A checklist will be maintained for the employee files to ensure all required components are contained within the file. A random audit will be conducted by the Administrator/designee monthly for a duration of 12 months to monitor for all required components. The Administrator will report these results monthly to the Quality Assurance Committee. The QA Committee can make recommendations as necessary.	07/22/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	05/23/2011

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	1. The employee file of LPN #3 was reviewed, on 5/17/11 at 10:00 A.M., and indicated that a record of the employee's job description had not been maintained. 2. The employee file of LPN #4 was reviewed on 5/17/11 at 10:00 A.M., and indicated that there was no record of job specific orientation maintained. During an interview with the Director of Nursing, on 5/19/11 at 3:00 p.m., she indicated that the facility had no other records of job description and orientation for LPN #3 and LPN #4. 3.1-14(q)(6) 3.1-14(q)(7) 2. Initial orientation of all staff must be conducted and documented and shall include the following: (l) Instructions on the needs of the specialized population or populations served in the facility, for example: (E) care of cognitively impaired residents; (2) A review of residents' rights and other pertinent portions of the facility's policy manual. This State Rule was not met as evidenced by:			

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	Based on record review and interview, the facility failed to ensure orientation to care of cognitively impaired residents and orientation to residents' rights for LPN #4. This impacted 1 of 12 employees' records reviewed for orientation in a sample of 12 employees. Findings include: The employee file of LPN #4 was reviewed on 5/17/11 at 10:00 A.M., and indicated a hire date of 1/13/11. There was no record of orientation for care of cognitively impaired residents or orientation of residents' nights. During an interview with the Director of Nursing on 5/19/11 at 3:00 p.m., she indicated that the facility did not have any other records of orientation of care of cognitively impaired residents or review of residents' rights for LPN #4. 3.1-14(p)(1)(E) 3.1-14(p)(2)			